

Facility Name & ID Number GRASMERE PLACE

0044271 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	Skilled (SNF)			1
2	Skilled Pediatric (SNF/PED)			2
3	216Intermediate (ICF)	216	78,840	3
4	Intermediate/DD			4
5	Sheltered Care (SC)			5
6	ICF/DD 16 or Less			6
7	216TOTALS	216	78,840	7

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Public Aid Recipient	Private Pay	Other	Total	
8	SNF				8
9	SNF/PED				9
10	ICF	75,388	28	75,416	10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	75,388	28	75,416	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.66%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid? 2,180 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 2/1/99

J. Was the facility purchased or leased after January 1, 1978? YES X Date 2/1/99 NO

K. Was the facility certified for Medicare during the reporting year? YES NO X If YES, enter number of beds certified and days of care provided Medicare Intermediary

IV. ACCOUNTING BASIS

ACCUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	160,851	29,351	18,480	208,682		208,682	(5,554)	203,128			1
2	Food Purchase		239,786		239,786	(27,448)	212,338	(169)	212,169			2
3	Housekeeping	188,575	32,213		220,788		220,788	(603)	220,185			3
4	Laundry		6,396	20,784	27,180		27,180		27,180			4
5	Heat and Other Utilities			119,008	119,008		119,008	1,952	120,960			5
6	Maintenance	133,993		104,399	238,392		238,392	1,612	240,004			6
7	Other (specify):*							2,448	2,448			7
8	TOTAL General Services	483,419	307,746	262,671	1,053,836	(27,448)	1,026,388	(314)	1,026,074			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	918,505	21,594	6,078	946,177		946,177	11,384	957,561			10
10a	Therapy											10a
11	Activities	237,573	10,903	4,755	253,231		253,231	24	253,255			11
12	Social Services	448,845	4,671	15,221	468,737		468,737	16	468,753			12
13	Nurse Aide Training											13
14	Program Transportation			28	28		28		28			14
15	Other (specify):*							2,623	2,623			15
16	TOTAL Health Care and Programs	1,604,923	37,168	33,282	1,675,373		1,675,373	14,047	1,689,420			16
	C. General Administration											
17	Administrative			290,197	290,197		290,197	38,879	329,076			17
18	Directors Fees											18
19	Professional Services			337,091	337,091		337,091	(284,596)	52,495			19
20	Dues, Fees, Subscriptions & Promotions			61,345	61,345		61,345	(26,821)	34,524			20
21	Clerical & General Office Expenses	129,769	13,295	133,203	276,267		276,267	49,986	326,253			21
22	Employee Benefits & Payroll Taxes			396,935	396,935	27,448	424,383	(21,569)	402,814			22
23	Inservice Training & Education			2,627	2,627		2,627		2,627			23
24	Travel and Seminar			650	650		650	1,124	1,774			24
25	Other Admin. Staff Transportation			7,126	7,126		7,126	(4,860)	2,266			25
26	Insurance-Prop.Liab.Malpractice			80,035	80,035		80,035	1,373	81,408			26
27	Other (specify):*							38,873	38,873			27
28	TOTAL General Administration	129,769	13,295	1,309,209	1,452,273	27,448	1,479,721	(207,611)	1,272,110			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,218,111	358,209	1,605,162	4,181,482		4,181,482	(193,878)	3,987,604			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			74,636	74,636		74,636	302,272	376,908			30
31	Amortization of Pre-Op. & Org.							69,443	69,443			31
32	Interest			124	124		124	728,355	728,479			32
33	Real Estate Taxes			128,780	128,780		128,780	3,388	132,168			33
34	Rent-Facility & Grounds			914,544	914,544		914,544	(909,311)	5,233			34
35	Rent-Equipment & Vehicles			9,504	9,504		9,504	3,802	13,306			35
36	Other (specify):*							47,220	47,220			36
37	TOTAL Ownership			1,127,588	1,127,588		1,127,588	245,169	1,372,757			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,260	118,260		118,260		118,260			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			118,260	118,260		118,260		118,260			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,218,111	358,209	2,851,010	5,427,330		5,427,330	51,291	5,478,621			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(70,948)	30		9
10	Interest and Other Investment Income	(86,289)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	21		24
25	Fund Raising, Advertising and Promotional	(5,465)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(31,670)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (254,373)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	305,664		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 305,664		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 51,291		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS		Page 5A
GRASMERE PLACE		
ID# 0044371		
Report Period Beginning: 01/01/02		
Ending: 12/31/02		
NON-ALLOWABLE EXPENSES		Sch. V Line
		Amount Reference
1	COPI	(3,157) 20 1
2	Capitalized R&M	(4,466) 06 2
3	Collection Expense	(190) 21 3
4	Bank Charges	(7,302) 21 4
5	Penalties	(10,000) 21 5
6	Theft Loss	(64) 21 6
7	Business Tax (PPA)	(2,538) 21 7
8	SU/TA (PPA)	(904) 22 8
9	Misc Income	(400) 21 9
10	Jury Duty Income	(86) 10 10
11	Prior Year Legal Fees	(2,859) 19 11
12	Bank Charges - Bldg Co.	(4) 21 12
13	Trust Fees - Bldg Co.	(300) 21 13
14	LLC Fee - Bldg Co.	(300) 21 14
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101	Total	(31,670) 101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GRASMERE PLACE

0044271

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary					(1,935)		(3,619)					(5,554)	1
2	Food Purchase	(1)		(168)									(169)	2
3	Housekeeping							(603)					(603)	3
4	Laundry													4
5	Heat and Other Utilities			1,952									1,952	5
6	Maintenance	(4,466)		3,819		2,259							1,612	6
7	Other (specify):*				1,339	1,109							2,448	7
8	TOTAL General Services	(4,467)		5,603	1,339	1,433		(4,222)					(314)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(86)		(47)		13,997		(2,480)					11,384	10
10a	Therapy													10a
11	Activities			2	22								24	11
12	Social Services					16							16	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				695	1,928							2,623	15
16	TOTAL Health Care and Programs	(86)		(45)	717	15,941		(2,480)					14,047	16
	C. General Administration													
17	Administrative			460	(684)	39,103							38,879	17
18	Directors Fees													18
19	Professional Services	(2,059)		(282,537)									(284,596)	19
20	Fees, Subscriptions & Promotions	(8,622)		(18,199)									(26,821)	20
21	Clerical & General Office Expenses	(80,998)	504	18,831		111,649							49,986	21
22	Employee Benefits & Payroll Taxes	(904)			(20,665)								(21,569)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,124									1,124	24
25	Other Admin. Staff Transportation			(4,860)									(4,860)	25
26	Insurance-Prop.Liab.Malpractice			1,373									1,373	26
27	Other (specify):*				17,634	21,239							38,873	27
28	TOTAL General Administration	(92,583)	504	(283,808)	(3,715)	171,991							(207,611)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(97,136)	504	(278,250)	(1,659)	189,365		(6,702)					(193,878)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(70,948)	359,763	13,457									302,272	30
31	Amortization of Pre-Op. & Org.		69,443										69,443	31
32	Interest	(86,289)	800,292	14,352									728,355	32
33	Real Estate Taxes			3,388									3,388	33
34	Rent-Facility & Grounds		(914,544)	5,233									(909,311)	34
35	Rent-Equipment & Vehicles			3,802									3,802	35
36	Other (specify):*		47,220										47,220	36
37	TOTAL Ownership	(157,237)	362,174	40,232									245,169	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(254,373)	362,678	(238,018)	(1,659)	189,365		(6,702)					51,291	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		
				Grasmere Real Estate, LLC		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Expense	\$ 914,544	Grasmere Real Estate, LLC		\$	\$(914,544)	1
2	V	32	Interest Income		Grasmere Real Estate, LLC		(7,216)	(7,216)	2
3	V	21	Bank Charges		Grasmere Real Estate, LLC		4	4	3
4	V	21	Trust Fees		Grasmere Real Estate, LLC		200	200	4
5	V	32	Interest - Mortgage		Grasmere Real Estate, LLC		807,508	807,508	5
6	V	21	LLC Fee		Grasmere Real Estate, LLC		300	300	6
7	V	36	MIP Insurance		Grasmere Real Estate, LLC		47,220	47,220	7
8	V	31	Amortization		Grasmere Real Estate, LLC		69,443	69,443	8
9	V	30	Depreciation		Grasmere Real Estate, LLC		359,763	359,763	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 914,544			\$ 1,277,222	\$ * 362,678	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	05	Utilities	\$	Care Centers, Inc.	100.00%	\$ 1,952	\$ 1,952	15
16	V	06	Maintenance		Care Centers, Inc.	100.00%	3,819	3,819	16
17	V	10	Nursing	56	Care Centers, Inc.	100.00%	9	(47)	17
18	V	11	Activities		Care Centers, Inc.	100.00%	2	2	18
19	V	19	Professional Fees	293,910	Care Centers, Inc.	100.00%	11,373	(282,537)	19
20	V	20	Dues and Subscriptions	19,710	Care Centers, Inc.	100.00%	1,511	(18,199)	20
21	V	21	Office & Clerical		Care Centers, Inc.	100.00%	18,831	18,831	21
22	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	1,124	1,124	22
23	V	26	Insurance		Care Centers, Inc.	100.00%	1,373	1,373	23
24	V	30	Depreciation		Care Centers, Inc.	100.00%	13,457	13,457	24
25	V	32	Interest		Care Centers, Inc.	100.00%	14,352	14,352	25
26	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	3,388	3,388	26
27	V	34	Rent - Building		Care Centers, Inc.	100.00%	5,233	5,233	27
28	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	3,802	3,802	28
29	V	25	Bus Reimbursement	4,860	Care Centers, Inc.	100.00%		(4,860)	29
30	V	02	Food	168	Care Centers, Inc.	100.00%		(168)	30
31	V	17	Administration		Care Centers, Inc.	100.00%	460	460	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 318,704			\$ 80,686	\$ * (238,018)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping Salary	\$	Care Centers, Inc.	100.00%	\$	\$	15
16	V	06	Maintenance Salary	9,876	Care Centers, Inc.	100.00%	9,876		16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,339	1,339	17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%			18
19	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			19
20	V	11	Activity Salary	4,019	Care Centers, Inc.	100.00%	4,041	22	20
21	V	12	Social Service Salary	1,166	Care Centers, Inc.	100.00%	1,166		21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	695	695	22
23	V	17	Administration Salary	98,197	Care Centers, Inc.	100.00%	97,513	(684)	23
24	V	21	Office Salary	25,210	Care Centers, Inc.	100.00%	25,210		24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	17,634	17,634	25
26	V	22	Employee Benefits	20,665	Care Centers, Inc.	100.00%		(20,665)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 159,133			\$ 157,474	\$ * (1,659)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	\$ 7,884	Care Centers, Inc.	100.00%	\$ 5,949	\$ (1,935)	15
16	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	2,259	2,259	16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,109	1,109	17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%	13,997	13,997	18
19	V	12	Social Service Salary		Care Centers, Inc.	100.00%	16	16	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,928	1,928	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	39,103	39,103	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	111,649	111,649	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	21,239	21,239	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 7,884			\$ 197,249	\$ * 189,365	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Care Centers, Inc. - Health Systems Division	100.00%	\$	\$	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%			16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%			17
18	V	10	Nursing		Care Centers, Inc. - Health Systems Division	100.00%			18
19	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%			19
20	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%			20
21	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%			21
22	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%			22
23	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%			23
24	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%			24
25	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%			25
26	V	39	Ancillary Enteral Supplies		Care Centers, Inc. - Health Systems Division	100.00%			26
27	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%			27
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%			28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$ 26,709	XCEL Medical Supply, LLC	100.00%	\$ 23,090	\$ (3,619)	15
16	V	03	Housekeeping	4,451	XCEL Medical Supply, LLC	100.00%	3,848	(603)	16
17	V	10	Nursing	18,301	XCEL Medical Supply, LLC	100.00%	15,821	(2,480)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 49,461			\$ 42,759	\$ * (6,702)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 96,280	\$ 96,280	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	96,280				(96,280)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 96,280			\$ 96,280	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative		see attached	2.25	3.13%	Mgmt Fee	\$ 180,000	17-3	1
2	Mark Steinberg	Relative	Administrative		see attached	2.3	4.60%	CCI salary	2,081	17-7	2
3	Melissa Rothner	Owner	Clerical	1.85%	see attached			CCI salary	46	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 182,127		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Care Centers, Inc.
Street Address 2202 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	05	Utilities	Patient Days	1,640,756	39	\$ 42,470	\$	75,416	\$ 1,952	1
2	06	Maintenance	Patient Days	1,640,756	39	83,080		75,416	3,819	2
3	10	Nursing	Patient Days	1,640,756	39	205		75,416	9	3
4	11	Activities	Patient Days	1,640,756	39	51		75,416	2	4
5	19	Professional Fees	Patient Days	1,640,756	39	247,437		75,416	11,373	5
6	20	Dues and Subscriptions	Patient Days	1,640,756	39	32,863		75,416	1,511	6
7	21	Office & Clerical	Patient Days	1,640,756	39	409,698		75,416	18,831	7
8	24	Travel and Seminar	Patient Days	1,640,756	39	53,743		75,416	1,124	8
9	26	Insurance	Patient Days	1,640,756	39	29,875		75,416	1,373	9
10	30	Depreciation	Patient Days	1,640,756	39	292,776		75,416	13,457	10
11	32	Interest	Patient Days	1,640,756	39	312,254		75,416	14,352	11
12	33	Real Estate Taxes	Patient Days	1,640,756	39	73,702		75,416	3,388	12
13	34	Rent - Building	Patient Days	1,640,756	39	113,857		75,416	5,233	13
14	35	Rent - Equipment & Auto	Patient Days	1,640,756	39	82,710		75,416	3,802	14
15	17	Administration	Patient Days	1,640,756	39	10,000		75,416	460	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,784,721	\$		\$ 80,686	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Care Centers, Inc.
Street Address 2202 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	03	Housekeeping Salary	Direct Cost			45,667	45,667			1
2	06	Maintenance Salary	Direct Cost			169,934	169,934		9,876	2
3	07	Emp. Ben. - Gen. Serv.	Direct Cost			29,646			1,339	3
4	10	Nursing Salary	Direct Cost			895,582	895,582			4
5	10a	Rehab Salary	Direct Cost			128,376	128,376			5
6	11	Activity Salary	Direct Cost			57,201	57,201		4,041	6
7	12	Social Service Salary	Direct Cost			219,790	219,790		1,166	7
8	15	Emp. Ben. - Healthcare	Direct Cost			180,204			695	8
9	17	Administration Salary	Direct Cost			1,334,207	1,334,207		97,513	9
10	21	Office Salary	Direct Cost			584,278	584,278		25,210	10
11	27	Emp. Ben. - Gen. Admin.	Direct Cost			267,060			17,634	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,911,943	\$ 3,435,033		\$ 157,474	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Care Centers, Inc.
Street Address 2202 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,640,756	39	129,417	129,417	75,416	5,949	1
2	06	Maintenance Salary	Patient Days	1,640,756	39	49,148	49,148	75,416	2,259	2
3	07	Emp. Ben. - Gen. Serv.	Patient Days	1,640,756	39	24,132		75,416	1,109	3
4	10	Nursing Salary	Patient Days	1,640,756	39	304,530	304,530	75,416	13,997	4
5	12	Social Service Salary	Patient Days	1,640,756	39	354	354	75,416	16	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,640,756	39	41,952		75,416	1,928	6
7	17	Administration Salary	Patient Days	1,640,756	39	850,731	850,731	75,416	39,103	7
8	21	Office Salary	Patient Days	1,640,756	39	2,429,052	2,429,052	75,416	111,649	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,640,756	39	462,069		75,416	21,239	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,291,386	\$ 3,763,233		\$ 197,249	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Care Centers, Inc.
Street Address 2202 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,191,458		182,448				1
2	02	Food	Billable Income	2,191,458		834,365				2
3	06	Maintenance	Billable Income	2,191,458		1,400				3
4	10	Nursing	Billable Income	2,191,458		850				4
5	17	Administration	Billable Income	2,191,458		23,000				5
6	19	Professional Fees	Billable Income	2,191,458		46,205				6
7	20	Dues & Subscriptions	Billable Income	2,191,458		2,514				7
8	21	Office & Clerical	Billable Income	2,191,458		33,124				8
9	24	Travel & Seminar	Billable Income	2,191,458		49,456				9
10	34	Rent - Building	Billable Income	2,191,458		1,300				10
11	35	Rent - Equipment & Auto	Billable Income	2,191,458		1,830				11
12	39	Ancillary Enteral Supplies	Billable Income	2,191,458		84,436				12
13	01	Dietary - Salary	Billable Income	2,191,458		436,887	436,887			13
14	07	Emp. Ben. - Gen. Serv.	Billable Income	2,191,458		58,714				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,756,530	\$ 436,887		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Xcel Medical Supply, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, IL 60202
Phone Number (847) 328-7600
Fax Number (847) 328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			\$	\$		\$ 23,090	1
2	03	Housekeeping	Direct Allocation						3,848	2
3	10	Nursing	Direct Allocation						15,821	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 42,759	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address 2201 W. MAIN ST.
City / State / Zip Code EVANSTON, IL 60202
Phone Number (847) 905-4000
Fax Number (847) 905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			\$	\$		\$ 96,280	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 96,280	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Building Partnership			Mortgage	\$71,078.00	01/26/99	\$ 9,518,795	\$ 9,420,757			\$ 807,508	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$71,078.00		\$ 9,518,795	\$ 9,420,757			\$ 807,508	9	
	B. Non-Facility Related*												
10	See Supplemental Schedule										(79,153)	10	
11	Interest Expense										124	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (79,029)	14	
15	TOTALS (line 9+line14)						\$ 9,518,795	\$ 9,420,757			\$ 728,479	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 47,220 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income						\$				\$ (86,289)	1
2	Care Centers allocation										14,352	2
3	Interest Income - Bldg Co										(7,216)	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$	\$			\$ (79,153)	21

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

GRASMERE PLACE

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0044271

CONTACT PERSON REGARDING THIS REPORT

STEVEN LAVENDA

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	14-17-214-001-0000	LONG TERM CARE PROPERTY	\$ 113,011.48	\$ 113,011.48
2.	14-17-214-002-0000	LONG TERM CARE PROPERTY	\$ 1,942.61	\$ 1,942.61
3.	14-17-214-003-0000	LONG TERM CARE PROPERTY	\$ 1,942.61	\$ 1,942.61
4.	SEE ATTACHED	HOME OFFICE ALLOCATION	\$ 70,261.69	\$ 3,229.52
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 187,158.39	\$ 120,126.22

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

GRASMERE PLACE

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0044271

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000

B. General Construction Type: Exterior Brick

Frame

Number of Stories 4

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred: 1,106,202

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 69,443

4. Dates Incurred:

Nature of Costs: Closing Costs, Goodwill

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1999	\$ 800,000	1
2	Allocation from CCI			19,333	2
3	TOTALS			\$ 819,333	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		6,001,180	159,391		180,162	20,771	688,912	68
69	Financial Statement Depreciation			45,321			(45,321)		69
70	TOTAL (lines 4 thru 69)		\$ 6,001,180	\$ 204,712		\$ 180,162	\$ (24,550)	\$ 688,912	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,001,180	\$ 204,712		\$ 180,162	\$ (24,550)	\$ 688,912	1
2	HVAC RENOVATION	1999	948		20	47	47	180	2
3	HVAC RENOVATION	1999	719		20	36	36	138	3
4	HVAC RENOVATION	1999	1,015		20	51	51	196	4
5	BOILER	1999	5,719		20	286	286	1,025	5
6	BOILER	1999	2,842		20	142	142	497	6
7	FLOORING	1999	512		20	26	26	91	7
8	FLOORING	1999	436		20	22	22	77	8
9	COVE BASE	1999	371		20	19	19	67	9
10	FLOORING	1999	4,704		20	235	235	803	10
11	BOILER	1999	875		20	44	44	143	11
12	KITCHEN WIRING	1999	7,805		20	390	390	1,235	12
13	PLUMBING RENOVATION	1999	777		20	39	39	124	13
14	FLOORING	1999	12,587		20	629	629	1,992	14
15	PLUMBING	1999	7,000		20	350	350	1,079	15
16	RADIATOR RENOV	1999	653		20	33	33	102	16
17	PAINTING	1999	507		20	25	25	77	17
18	DRYWALL	1999	8,700		20	435	435	1,341	18
19	PLUMBING	1999	939		20	47	47	145	19
20	SPRINKLERS	1999	899		20	45	45	139	20
21	EQUIPMENT REPAIR	1999	719		20	36	36	138	21
22	A/C UNITS	1999	890		20	45	45	161	22
23	COMPRESSOR	1999	1,695		20	85	85	305	23
24	WATER HEATER	1999	1,406		20	70	70	251	24
25	ALARM COVERS	1999	1,150		20	58	58	208	25
26	COOLER RENOVATION	1999	1,152		20	58	58	198	26
27	CALL BUTTONS	1999	981		20	49	49	159	27
28	WATER HEATER	1999	819		20	41	41	130	28
29	A/C RENOV	1999	750		20	38	38	117	29
30	BOILER	1999	544		20	27	27	90	30
31	PAINT	1999	15,000		20	750	750	2,188	31
32	INSTALL TILES	2000	18,700		20	935	935	2,805	32
33	INSTALL CONCRETE	2000	1,500		20	75	75	225	33
34	TOTAL (lines 1 thru 33)		\$ 6,104,494	\$ 204,712		\$ 185,330	\$ (19,382)	\$ 705,338	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,104,494	\$ 204,712		\$ 185,330	\$ (19,382)	\$ 705,338	1
2	PLUMBING RENOV	2000	4,630		20	232	232	696	2
3	INSTALL CARPETING	2000	588		20	29	29	87	3
4	INSTALL VCT TILE	2000	1,569		20	78	78	234	4
5	PAINT	2000	1,046		20	52	52	156	5
6	ELECTRIC RENOV	2000	10,037		20	502	502	1,506	6
7	INSTALL GREASE TRAP	2000	1,142		20	57	57	166	7
8	PAINT	2000	1,450		20	73	73	213	8
9	KITCHEN REMODELING	2000	33,147		20	1,657	1,657	4,833	9
10	DEADLOCKS	2000	626		20	31	31	88	10
11	PAINT	2000	4,866		20	243	243	689	11
12	REFRIGE RENOV	2000	2,200		20	110	110	312	12
13	STEEL DOORS	2000	3,300		20	165	165	468	13
14	PLASTER	2000	15,000		20	750	750	2,063	14
15	PAINT	2000	2,611		20	261	261	718	15
16	RADIATOR RENOV	2000	1,616		20	81	81	223	16
17	PLASTER/PAINT	2000	20,000		20	1,000	1,000	2,667	17
18	PLASTER/PAINT	2000	2,500		20	125	125	333	18
19	DEPOSIT	2000	17,000		20	850	850	2,267	19
20	LANDSCAPING	2000	2,001		20	100	100	258	20
21	HOT WATER HEATER REP	2000	500		20	25	25	65	21
22	FRONT DOOR REPAIR	2000	650		20	33	33	85	22
23	ELECTRIC WIRING	2000	21,450		20	1,073	1,073	2,772	23
24	CARPETING INSTALL	2000	11,844		20	592	592	1,529	24
25	FRONT DOOR REPAIR	2000	675		20	34	34	85	25
26	ELECTRICAL WIRING	2000	1,923		20	96	96	224	26
27	PLUMBING REPAIR	2000	653		20	33	33	74	27
28	ELEVATOR REPAIR	2000	4,476		20	224	224	504	28
29	ROOF REPAIR	2000	7,220		20	361	361	812	29
30	FIRE PUMP REPAIR	2000	1,867		20	93	93	225	30
31	BINDER ELECTRIC	2000	6,332		20	317	317	766	31
32	FURNITURE FOR PARK	2000	12,695		20	635	635	1,535	32
33	INSTALLN OF BSKTBL S	2000	2,304		20	115	115	278	33
34	TOTAL (lines 1 thru 33)		\$ 6,302,412	\$ 204,712		\$ 195,357	\$ (9,355)	\$ 732,269	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,302,412	\$ 204,712		\$ 195,357	\$ (9,355)	\$ 732,269	1
2	NURSING STATION CBNT	2000	7,065		20	353	353	765	2
3	COOLER RENOV	2000	3,052		20	153	153	332	3
4	FIRE ALARM	2000	3,169		20	158	158	342	4
5	PLUMBING SUPPLIES	2000	980		20	49	49	106	5
6	FIRE ALARM REPAIR	2000	2,495		20	125	125	260	6
7	BOILER REPAIR	2000	2,629		20	131	131	273	7
8	LAVATORY REMODELING	2000	603		20	30	30	63	8
9	REPLACEMENT PIPING	2000	4,996		20	250	250	521	9
10	INSTALLATION OF RDTR	2000	1,507		20	75	75	156	10
11	RADIATOR REPAIR	2000	564		20	28	28	58	11
12	DRAPES	2000	4,840		20	242	242	504	12
13	CALL STATION REPAIR	2000	939		20	47	47	98	13
14	PLUMBING SUPPLIES	2000	980		20	49	49	102	14
15	PLUMBING	2000	653		20	33	33	131	15
16	PLUMBING	2000	1,691		20	85	85	325	16
17	WATER HEATER RENOV	2000	1,603		20	80	80	307	17
18	TOILETS	2000	574		20	29	29	106	18
19	COOLER RENOV	2000	518		20	26	26	91	19
20	TOILETS	2000	653		20	33	33	109	20
21	TOILETS	2000	653		20	33	33	109	21
22	PLUMBING REPAIR	2000	1,960		20	98	98	278	22
23	FOOD PROCESSOR	2000	930		20	47	47	125	23
24	NURSE CALL STATION R	2001	8,231		20	412	412	824	24
25	LAUNDRY ROOM LEAK RE	2001	4,748		20	237	237	474	25
26	PIPING REPAIR	2001	532		20	27	27	54	26
27		2001	600		20	30	30	60	27
28	NEW RODS DRAPES	2001	765		20	38	38	76	28
29	HEATING SYSTEM REPAI	2001	2,283		20	114	114	219	29
30	WATER LEAK REPAIR	2001	1,208		20	60	60	115	30
31	HEATING SYSTEM REPAI	2001	536		20	27	27	52	31
32	FLOOR TILES	2001	2,137		20	107	107	196	32
33	PLUMBING REPAIR IN M	2001	2,031		20	102	102	187	33
34	TOTAL (lines 1 thru 33)		\$ 6,368,537	\$ 204,712		\$ 198,665	\$ (6,047)	\$ 739,687	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,368,537	\$ 204,712		\$ 198,665	\$ (6,047)	\$ 739,687	1
2	ELECTRICAL SUPPLIES	2001	1,574		20	79	79	145	2
3	BATHROOM REMODELING	2001	1,000		20	50	50	92	3
4	BATHROOM REMODELING	2001	1,200		20	60	60	110	4
5	PAINT	2001	1,351		20	68	68	108	5
6	LANDSCAPING	2001	2,115		20	106	106	168	6
7	PLANS FOR ELEC.WORK	2001	660		20	33	33	52	7
8	AC REPAIR	2001	2,065		20	103	103	155	8
9	AC REPAIR	2001	510		20	26	26	39	9
10	BOILER REPAIR	2001	3,279		20	164	164	232	10
11	PLUMBING REPAIR-KITC	2001	1,886		20	94	94	133	11
12	BOILER ROOM REPAIR	2001	2,160		20	108	108	153	12
13	SLIDING GATE	2001	1,840		20	92	92	130	13
14	FIREBRICK BACKUP SYS	2001	2,297		20	115	115	153	14
15	TILES	2001	841		20	42	42	56	15
16	PLUMBING REPAIR	2001	1,057		20	53	53	66	16
17	CARPETING	2001	6,145		20	307	307	358	17
18	TILES	2001	634		20	32	32	37	18
19	PLUMBING REPAIR	2001	4,000		20	200	200	233	19
20	PLUMBING REPAIR	2001	2,052		20	103	103	120	20
21	SPRINKLER SYSTEM REP	2001	1,750		20	88	88	103	21
22	FREEZER REPAIR	2002	968		20	32	32	32	22
23	BATHROOM REMODELING	2002	20,979		20	2,098	2,098	2,098	23
24	WATER LEAK REPAIR	2002	767		20	77	77	77	24
25	CONTROL CABINET FOR BOILER ROOM	2002	4,670		20	467	467	467	25
26	PLUMBING SUPPLIES	2002	772		20	77	77	77	26
27	PLUMBING SUPPLIES	2002	568		20	57	57	57	27
28	PUMP REPAIR	2002	1,832		20	183	183	183	28
29	PUMP REPAIR	2002	670		20	67	67	67	29
30	BOILER REPAIR	2002	2,159		20	216	216	216	30
31	DRINKING FOUNTAIN INSTALLATION	2002	509		20	51	51	51	31
32	TUB LEAK REPAIR	2002	647		20	65	65	65	32
33	SHOWER LEVER	2002	600		20	60	60	60	33
34	TOTAL (lines 1 thru 33)		\$ 6,442,094	\$ 204,712		\$ 204,038	\$ (674)	\$ 745,780	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,442,094	\$ 204,712		\$ 204,038	\$ (674)	\$ 745,780	1
2	NEW DRYWALL IN 3 BATHROOMS	2002	12,600		20	1,155	1,155	1,155	2
3	PLUMBING REPAIR	2002	877		20	80	80	80	3
4	PLUMBING REPAIR	2002	2,988		20	274	274	274	4
5	TOILET REPAIR	2002	541		20	50	50	50	5
6	ELECTRIC WIRING	2002	768		20	64	64	64	6
7	PLUMBING REPAIR	2002	661		20	55	55	55	7
8	PAINT	2002	957		20	72	72	72	8
9	PAINT	2002	1,899		20	127	127	127	9
10	PAINT	2002	861		20	57	57	57	10
11	ROOF DRAIN REPAIR	2002	614		20	41	41	41	11
12	PAINT	2002	542		20	32	32	32	12
13	ROOF DRAIN REPAIR	2002	594		20	35	35	35	13
14	CALL LIGHTS REPLACEMENT	2002	1,197		20	70	70	70	14
15	PLUMBING REPAIR	2002	866		20	51	51	51	15
16	LANDSCAPING	2002	1,956		20	76	76	76	16
17	TUCKPOINTING	2002	3,000		20	150	150	150	17
18	KEY BY CODE	2002	852		20	43	43	43	18
19	BUILDERS HARDWARE	2002	535		20	22	22	22	19
20	TUCKPOINTING	2002	8,475		20	353	353	353	20
21	FIRE ESCAPE REPAIR	2002	5,250		20	219	219	219	21
22	FIRE ESCAPE REPAIR	2002	2,500		20	104	104	104	22
23	TILES	2002	530		20	22	22	22	23
24	GASKETS INSTALLATION	2002	1,135		20	47	47	47	24
25	DRYWALL	2002	550		20	18	18	18	25
26	ELECTRICAL SUPPLIES	2002	1,499		20	50	50	50	26
27	TUCKPOINTING	2002	1,700		20	57	57	57	27
28	QUARTER ROUND (455)	2002	699		20	17	17	17	28
29	VCT TILE	2002	2,007		20	50	50	50	29
30	PAINT	2002	2,939		20	73	73	73	30
31	DURO-LAST ROOF	2002	2,900		20	73	73	73	31
32	WINDOW LINTEL REPLACEMENT	2002	2,500		20	63	63	63	32
33	BOILER REPAIR	2002	1,455		20	36	36	36	33
34	TOTAL (lines 1 thru 33)		\$ 6,508,541	\$ 204,712		\$ 207,674	\$ 2,962	\$ 749,416	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 6,508,541	\$ 204,712		\$ 207,674	\$ 2,962	\$ 749,416	1
2	THERMOPAK BOILER	2002	1,425		20	36	36	36	2
3	VCT TILE	2002	641		20	16	16	16	3
4	THERMOPACK BOILER	2002	7,856		20	131	131	131	4
5	ELEVATOR REPAIR	2002	3,741		20	62	62	62	5
6	PAINT	2002	695		20	12	12	12	6
7	REPLACE PIPING	2002	1,325		20	22	22	22	7
8	REPLACE PIPING	2002	802		20	13	13	13	8
9	LINTEL REPLACEMENT	2002	21,000		20	350	350	350	9
10	WATER LEAK REPAIR-BOILER ROOM	2002	987		20	99	99	99	10
11	SHOWER DOORS	2002	1,095		20	164	164	164	11
12	AC	2002	603		20	43	43	43	12
13	AC	2002	2,995		20	214	214	214	13
14	PLUMBING SUPPLIES	2002	703		20	59	59	59	14
15	AC	2002	2,236		20	133	133	133	15
16	TILES	2002	2,634		20				16
17	PAINT	2002	1,832		20				17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,559,111	\$ 204,712		\$ 209,028	\$ 4,316	\$ 750,770	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 6,559,111	\$ 204,712		\$ 209,028	\$ 4,316	\$ 750,770	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,559,111	\$ 204,712		\$ 209,028	\$ 4,316	\$ 750,770	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 6,559,111	\$ 204,712		\$ 209,028	\$ 4,316	\$ 750,770	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,559,111	\$ 204,712		\$ 209,028	\$ 4,316	\$ 750,770	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 6,559,111	\$ 204,712		\$ 209,028	\$ 4,316	\$ 750,770	1
2									2
3									3
4									4
5									5
6									6
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,559,111	\$ 204,712		\$ 209,028	\$ 4,316	\$ 750,770	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 6,559,111	\$ 204,712		\$ 209,028	\$ 4,316	\$ 750,770	1
2									2
3									3
4									4
5									5
6									6
7									7
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9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,559,111	\$ 204,712		\$ 209,028	\$ 4,316	\$ 750,770	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1999		\$ 5,578,000	\$ 143,026	35	\$ 159,371	\$ 16,345	\$ 624,203	4
5	Care Center allocation		1996			1,224	35	1,363	139		5
6	Care Center allocation		2002		26,641	50	35	74	24	74	6
7											7
8											8
	Improvement Type**										
9	Care Center allocation		2002			454	20	31	(423)		9
10	Care Center allocation		2001			1	20	7	6		10
11	Care Center allocation		2000			1	20	3	2		11
12	Care Center allocation		1999			22	20	43	(21)		12
13	Care Center allocation		1998			9	20	18	9		13
14	Care Center allocation		1997			88	20	176	88		14
15	Care Center allocation		1996			228	20	349	121		15
16	Care Center allocation		1997			1	20	29	28		16
17	Care Center allocation		1994			11	20		(11)		17
18	Care Center allocation		1993			5	20		(5)		18
19	Care Center allocation		2002		24,668	46	20	103	57	103	19
20											20
21	Grasmere Real Estate LLC		1999		192,580	9,629	20	9,629		35,306	21
22	Grasmere Real Estate LLC		1999		19,311	495	20	966	471	3,381	22
23	Grasmere Real Estate LLC		1999		1,573	40	20	79	39	270	23
24	Grasmere Real Estate LLC		1999		50,131	1,285	20	2,507	1,222	8,357	24
25	Grasmere Real Estate LLC		1999		17,558	450	20	878	428	2,854	25
26	Grasmere Real Estate LLC		1999		90,718	2,326	20	4,536	2,210	14,364	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,001,180	\$ 159,391		\$ 180,162	\$ 20,729	\$ 688,912	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,497,873	\$232,872	\$157,515	\$(75,357)	10	\$573,871	71
72	Current Year Purchases	47,703	1,709	3,325	1,616	10	6,217	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,545,576	\$234,581	\$160,840	\$(73,741)		\$580,088	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		ESCORT	2001	\$8,270	\$1,654	\$827	\$(827)	5	\$1,034	76
77		VOLKSWAGEN NEW BEETLE	2002	11,329	1,699	1,699		5	1,699	77
78		CARE CENTERS ALLOCATION		30,964	5,209	4,513	(696)	5	16,933	78
79										79
80	TOTALS			\$50,563	\$8,562	\$7,039	\$(1,523)		\$19,666	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$8,974,583	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$447,855	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$376,907	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(70,948)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,350,524	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Care Centers allocation				5,233			5
6								6
7	TOTAL				\$ 5,233			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease.

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 11,683 Description: see attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrator		\$ 405.40	\$ 1,622	17
18					18
19					19
20					20
21	TOTAL		\$ 405.40	\$ 1,622	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year EndingAnnual Rent

12. /2003\$
13. /2004\$
14. /2005\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs			N/A				2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,810	\$ 4,135	1
2	Cash-Patient Deposits	24,494	24,494	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	943,624	943,624	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	122,259	149,716	6
7	Other Prepaid Expenses	63,387	63,387	7
8	Accounts Receivable (owners or related parties)	188,100	188,100	8
9	Other(specify): See Supplemental Schedule	1,666,330	2,298,315	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,012,004	\$ 3,671,771	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		800,000	13
14	Buildings, at Historical Cost		5,578,000	14
15	Leasehold Improvements, at Historical Cost	530,516	902,386	15
16	Equipment, at Historical Cost	157,506	1,528,839	16
17	Accumulated Depreciation (book methods)	(188,187)	(1,746,000)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	4,875	872,191	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 504,710	\$ 7,935,416	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,516,714	\$ 11,607,187	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 363,774	\$ 363,774	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,319	14,319	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,883	156,883	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,319	6,319	31
32	Accrued Real Estate Taxes(Sch.IX-B)	122,589	122,589	32
33	Accrued Interest Payable		67,123	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 663,884	\$ 731,007	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,420,757	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 9,420,757	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 663,884	\$ 10,151,764	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,852,830	\$ 1,455,423	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,516,714	\$ 11,607,187	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,206,639	1
2	Restatements (describe):		2
3	Adjust accumulated depreciation to GAAP schedule	(55,182)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,151,457	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,331,373	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(630,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 701,373	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,852,830	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,671,928	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,671,928	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	86,289	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 86,289	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	486	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 486	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,758,703	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,053,836	31
32	Health Care	1,675,373	32
33	General Administration	1,452,273	33
	B. Capital Expense		
34	Ownership	1,127,588	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	118,260	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,427,330	40
41	Income before Income Taxes (line 30 minus line 40)**	1,331,373	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,331,373	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number GRASMERE PLACE

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,912	2,136	\$ 59,677	\$ 27.94	1
2	Assistant Director of Nursing	1,736	2,160	54,533	25.25	2
3	Registered Nurses	127	127	2,472	19.46	3
4	Licensed Practical Nurses	16,426	18,386	329,401	17.92	4
5	Nurse Aides & Orderlies	53,101	57,646	457,072	7.93	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,904	2,177	39,197	18.01	9
10	Activity Assistants	7,448	8,294	63,898	7.70	10
11	Social Service Workers	27,501	30,857	448,845	14.55	11
12	Dietician					12
13	Food Service Supervisor	3,649	4,134	47,768	11.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,769	14,632	113,083	7.73	15
16	Dishwashers					16
17	Maintenance Workers	11,436	12,714	133,993	10.54	17
18	Housekeepers	23,699	25,322	188,575	7.45	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,158	11,223	129,769	11.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,748	1,915	15,350	8.02	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	27,956	28,437	134,478	4.73	33
34	TOTAL (lines 1 - 33)	202,570	220,160	\$ 2,218,111 *	\$ 10.07	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	220	\$ 10,596	01-03	35
36	Medical Director	monthly	7,200	09-03	36
37	Medical Records Consultant	monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,950	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	736	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Art Therapist	351	14,055	12-03	47
48	CCI Cost - see attached		13,069		48
49	TOTAL (lines 35 - 48)	587	\$ 51,734		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
			\$	Workers' Compensation Insurance	\$	34,036	IDPH License Fee	\$
				Unemployment Compensation Insurance		43,115	Advertising: Employee Recruitment	14,770
				FICA Taxes		164,185	Health Care Worker Background Check	3,120
				Employee Health Insurance		111,814	(Indicate # of checks performed 286)	
				Employee Meals		27,448	Advertising & Promotion	25,175
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	8,202
				Misc Employee Welfare		3,414	License & Fees	6,921
				Chicago Empl Tax		4,433	Care Centers allocation	1,511
				Pension Expense		14,339		
				Employee Physicals		30		
							Less: Public Relations Expense	()
							Non-allowable advertising	(25,175)
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
	Description		Amount		\$	402,814		\$
	Eric Rothner - Management Fee		\$ 180,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
	Nathan Langsner - Management Fee		12,000	Description	Line #	Amount	Description	Amount
	CCI Administrative Payroll (adjusted out page 6B)		98,197				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							In-State Travel	
C. Professional Services								
	Vendor/Payee	Type	Amount				Seminar Expense	650
	Various - see attached	Legal	\$ 10,792				Care Centers allocation	1,124
	Care Centers, Inc.	Various - see attached	293,910					
	Frost Ruttenberg & Rothblatt	Accounting	14,355				Entertainment Expense	()
	Paycor	Payroll	9,698				(agree to Sch. V, line 24, col. 8)	
	National Hotline	Compliance	234					
	Cindy Zola	IOC Consulting	33					
	LegatArchitects	Architect	2,728					
	TEG Services	Utility Mgmt Services	300					
	Personnel Planners	Unemployment Consult	5,042					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL	\$		TOTAL	\$
			\$ 337,092					1,774

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		GRASMERE PLACE		STATE OF ILLINOIS				Page 23
		#	0044271	Report Period Beginning:	01/01/02	Ending:	12/31/02	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
ICLTC \$10,342

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 0 Line

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 118,260

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

N/A

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 27,448
Indicate the amount. \$

(16)

Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents?
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

No
No
100%
No
Yes
N/A

g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?
If no, please explain.

No

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees

Yes

SEE ACCOUNTANTS' COMPILATION REPORT